Guidelines for Annual Sector Plan

Health Sector

Program Support Unit
Sindh Devolved Social Services Program
Finance Department
Govt. of Sindh

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A-I Performa: ABS(H)-II

A-II Performa: SCR(H)-I

A-III MoU

a. Introduction

The district health system (DHS) is the basic manageable unit, which can integrate health programs by adopting top down and bottom-up planning, and is capable of coordinating government and private sector efforts. Under Sindh Local Government Ordinance (SLGO) the district unit has further been reinforced and presence of district managers offer an opportunity to work as an effective team with support from all stake holders including other departments, NGOs, community and private sector.

Government of Sindh with assistance of Asian Development Bank has initiated Sindh Devolved Social Services Program (SDSSP), the overall goal of the SDSSP is to improve people's education and health, thereby helping to reduce poverty and gender imbalances. In health sector the primary objective is to improve overall health status of people through efficient and cost effective health service delivery to people. The activities in this direction include improvement maternal and child health care, improved immunization, efficient referral system and above all availability of qualified medics and paramedics in the health institutions.

SDSSP is a direct budgetary support to district governments and funds under programme are disbursed against Annual Sector Plans; which are duly approved by DGs.

b. Need for Health Sector Planning.

It is acknowledged fact that at present health sector is facing dual challenge of low sector financing and its in-efficient utilization. The major reason among others is improper planning due to this majority of district managers do not know what is available with them and what is required? Ultimately efficient utilization of resources always remains a hard task to achieve.

At this point in time when different donor agencies, philanthropists, social welfare organizations and NGOs are actively playing their role in social sector especially in health, it has become imperative for district governments to pool their available resources in terms of ***material, manpower, and money*** and work out for requirements based on identified gaps and preparation of ASP is primary document to highlight existing situation of facilities and mapping out all ongoing activities/interventions and future strategies so that all resources available at the disposal of DGs could be redirected and efficiently utilized.

Basic Qualifying Requirements for Preparation of Annual Sector Plan (ASP)

ASP specifying various schemes should be inline with parameters set out in Paras-4 & 6 of MoU, signed by the District Government with SDSSP, Finance Dept. Govt. of Sindh.

c. Methodology

Under the Sindh Local Government Ordinance, 2001 each District has formed Sector Committees and consequently each District has its own Health Sector Committee, Budget and Development Committee, Health Management Committee and Planning and Budgeting Committee working at council level. Involvement of these committees is pre-requisite for sector planning.

The district health management team (DHMT) was formed with the primary objective of preparation of Health Sector Plan. In most of the districts these teams are notified and functioning at the same time they may have certain capacity constraints to perform at optimum level. District authorities may take all steps to reactivate these committees so that more comprehensive and qualitative sectoral planning could be made. However, where these DHMTs are non-functioning EDO (H) in consultation with all stake holders shall prepare the plan. I**t is further expected that these committees would not only be limited in submitting the Annual Sector Plan before Council but will also play an proactive role in designing and processing the ASP for Health.**

d. Process of Planning as envisaged in SLGO.

1. Identification of schemes through a bottom up planning system.
2. Preparation of outlines of sector planning by concerned officers in consultation with council's sector committee (at least 2 female councilors as its members)
3. Approval of the sector plan outlines by Budget and Development Committee (at least 2 female councilors as its members)
4. Preparation of detailed annual sector plan proposal
5. Preparation of technical sanctions for schemes involving works
6. Approval by Budget and Development Committee
7. Issuance of Administrative Approval and Technical Sanction
8. Inclusion in Annual Development Program
9. Approval by Council.

e. Structure of ASP

The Planning cycle is a systematic process, which enables managers/ providers to determine how resources are used in relation to achieving their goals and objectives. In general we are considering following elements while preparing a Health Plan.

1. **Executive Summary**
2. **Vision**
3. **Situation Analysis**
4. **Resources Available for district.**
5. **Objectives/Targets**
6. **Strategies/Interventions/Activities**
7. **Indicators/Sources of Information**

f. Gender Mainstreaming

The alarming level of maternal mortality in the province with substantial rural urban disparity in availability and accessibility of maternal and child health, safe reproductive health practices, low prevalence of contraceptives make women more vulnerable. The disappointing progress in halting the MMR and IMR in itself is the challenge before policy makers. Sectoral planning process requires that all such vulnerable groups should be given specific priority. After devolution when planning and implementation has been given to the District Assemblies where women participation is adequate as well. It is expected that while formulating policies gender targeting and participation must be ensured besides, formulating gender targeted program **(please refer to annexure for guidelines on gender mainstreaming and participation**).

g. Poverty Targeting

Poverty targeting is global agenda agreed by 189 countries through Millennium development goals (MDGs). Pakistan's poverty reduction strategy paper (PRSP) provides guidelines for making investments in pro poor projects. Under Sindh poverty reduction strategy paper (SPRSP), Government of Sindh is committed to invest in pro poor projects. While making sectoral planning all District Governments are required to make schemes for most vulnerable groups like woman, children, elderly people and least developed areas of the district.

h. Public Private Partnership

The Sindh Devolved Social Services Program envisages participatory methods in implementation of the program at every stage. The program documents call for strengthening of the available opportunities as well as developing new ways to ensure community's involvement in governance and key stakeholders' in all the stages of development interventions. As per MoU (Clause (c) of para 4), signed between DG and GoS, DGs shall allocate 15% of the SDSSP grant for community Based Organization (CBOs). **The detailed guidelines in this regard are attached herewith as annexure.**

1.0 Situation Analysis (Where are we?)

The situation analysis is the process of analyzing and interpreting all information available from the various sources, on the current situation of the health system as it prevails within the specific geographic area under consideration. The specific purpose to (i) identify health problems, and of health (services) needs arising as a result of these problems (ii) determine causes and circumstances underlying these problems (iii) assess availability and adequacy of resources (iv)identify gaps and weaknesses in health care services in line with health problems and service needs.

1.1 District Profile

The knowledge of current situation is essential for sector planning. Here the evaluation of both qualitative and quantitative factors is essential. For example at quality side following factors can be examined

- The geographical landscape of the district.
- The unique social and cultural settings of the district.
- The poverty and gender profile, at district and sub-district levels.

  For poverty profiling please refer to Participatory Poverty Assessment of Sindh, P&D Deptt: 2003-04 and Sindh Poverty Reduction Strategy Paper (S-PRSP).

1.2 Health Facilities District/Taluka/RHCs/BHU/Dispensaries/MCH centers.

The basic information regarding existing situation of health facilities District/Taluka/RHC/BHU/MCH/Dispensaries services along with bed strength, no. of equipments available, no. of indoor and outdoor patient comparing population with availability of health facility gives total picture of health service delivery at the district level. Within the district some institutes may be performing well having good number of patients attending the OPD etc than the others, having this knowledge would enable the planners in resource allocation as well as locating the reason and causes of variations. This data can be tabulated as per Performa annexed.

1.2.i Health Units without adequate facilities in terms of equipments and staff.

1.2.ii Non-Functional Units.

1.3 Resource Availability.

A detailed review of resources will be undertaken. Review of resource availability implies checking both the current and future projected/promised resources in the district with respect to manpower, material, money. For that purpose inventories need to be prepared in all three aspects i.e, human resources, equipments/instruments and financial resources. **Under financial resource availability following information is required to see how these funds are allocated and utilized. Specific information includes budget (BE & RE) of last three years including development and non-development (salary non salary component) and utilization status of current allocations.**

It would also be relevant to identify different interventions in the districts in terms of material and manpower provided by different donors (UNICEF, NCHD providing doctors and paramedics) etc. This information could be best used when compiled facility wise.

2.0 On-Going /New Schemes.

Before launching to form Annual Sector Plan, an essential element of planning is to know "what is going on". Annexed tables would encapsulate all the development work going on in your district (both at Capital and at Revenue side).

2.1 Donor Assisted Schemes,

Government is not the only force that is working in the health sector. There are several vertical programs/donors/agencies/philanthropists/ and voluntary organizations working in the field of health sector especially in maternal and child health. In order to avoid duplication and have complementary effect of the Annual Sector Plan it is necessary that donor's efforts must be known to District Administration.

In addition to these some other programs/schemes are being carried out at district level as an additional support especially in areas of maternal and child health and other preventive activities like safe blood transfusion, HIV AIDS etc. A summary of such schemes can be provided to find gap between available resources and requirements of a particular health facility.

2.2 Any Other Scheme(s)

District Governments may provide details of any scheme that is not covered earlier (see table 2.4).

3.0 Second Year SDSSP Plan.

3.1 Approach:

- Utilization of SDSSP funds through CBOs/NGOs in Health Sector.
- Rationalization of Health Services.
- Quality Assurance
- Strengthening of Referral System..
- Avoidance of Duplication.

3.2 Sustainability of Schemes

It has been in common experience that often schemes are designed without taking into consideration the sustainability of schemes. It is expected that DGs would devise a well coordinated plan for inclusion of key stakeholders in the planning and implementation process such as involvement of community (local councilors, district council's sector committees). In addition to this a close and active liaison of EDO Health office with offices of EDO F&P, W&S, and CDD is also essential.

Following points should be taken in to consideration while evaluating the schemes

- Catchment area,
- Community participation
- Sanctioned posts at the facility,
- Current Staff position (Medcal /Paramedical)
- Non-salary budget allocation for the facility especially medicine, MR, and POL

3.3 Objectives/Targets (Where do we want to be)?

The ultimate objective of health planning process is to maintain and improve the health status of a given community. However, setting plan objectives is the process of defining what one want to achieve within given time in the light of earlier identified health needs and resource availability. In order to achieve specific goals objectives and targets can be planned as illustrated in the following example.

Example:

Aim: Improve Reproductive Health Services in District X.

Long Term Objective: MMR shall be reduced from current 350/100,000 to 300/100,000 within 04 years.

Short Term Objectives:

- All pregnant women in all villages of the district are given advice and referred to antenatal services within one year.
- By end of second year 80% of women delivering in villages of the district are assisted by trained birth attendants.

Targets: To achieve these objectives DHMT has to determine all of the following targets:

- No. of midwives trained.
- No. of training session to be held
- No. of tetanus injections to be given
- No. and frequency of prenatal visits
- %age of obstetrics complications to be seen at THQ/DHQ.

3.4 Utilization through CBOs /NGOs working in Health.

The SDSSP fund utilization for second year includes 15% spending through CBOs. Selection/Solicitation of these CBOs/NGOs will be done by DGs. It is also pertinent to mention that these CBOs may also include Health Boards. Therefore it is essential to have full information regarding working CBOs in the district along with area of expertise (table annexed).

It is also pertinent to mention that program document mentions that Health Boards are to be formed to manage hospital affairs and these boards are also eligible for financing as envisaged for CBOs. Districts therefore will move forward more swiftly for establishment of health boards in the hospitals and DGs may authorize health boards to collect, retain and use fees and user charges. The DGs are also required to provide financial assistance to health boards on a pilot basis. Detailed guidelines for selection of CBOs are attached.

3.5 Rationalization of Services.

Due to ban on employment especially on low paid employees both technical and non-technical staff the service delivery has become a real challenge for districts. In fact, health department has advertised to fill up all vacancies available in district and most probably all persons will be on board very soon. However, the challenge before district government is availability of well qualified and trained staff especially female staff at remote health facilities. Through various deliberations with district governments' it is also surfaced that **many health facilities have been provided with very sophisticated instruments and modern equipments costing million of rupees**,

however, they usually remain underutilized over the years for want of availability of qualified medical as well paramedical staff. This year district governments may plan a scheme to overcome shortage of staff giving priority to those units which can be made functional through availability of staff and have equipments. **In this regard district governments may redeploy or appoint facility based qualified staff on contract especially female staff after fulfilling all codal formalities in transparent manner.**

Besides recruitment, this shortage can also be met through training of available manpower. DGs need to identify those potential employees.

It is expected that this year's annual sector plan should include complete section on following:

- ✓ ***Total availability and requirement of staff.***
- ✓ ***Total Availability and requirement of equipment.***
- ✓ ***Total trained manpower medical and para medical available in the district please provide discipline in which training is obtained.***
- ✓ ***Further Requirement in the field of training.***

(Note: Requirements must be in accordance with the prescribed standards of MCH, BHUs, RHCs, THQs and DHQ)**.**

More over list of facilities which are understaffed / overstaffed should also be attached.

3.6 Quality Assurance.

The basic objective of all efforts taken in the health sector is to provide health care to the masses which is efficient as well as cost effective. ***Second year's SDSSP grant includes 10% allocation on the basis of performance of District in the health sector***.

District Government's are further expected to install monitoring mechanism to see the impact of different interventions.

Example:

- **Increase in indoor and outdoor patient's number after providing basic equipments and services at BHUs, RHCs, and DHQ.**
- **No of patients treated during 6 months after installation of Cardiac facility.**
- **No. of patients accessed diagnostic services after installation of laboratory facility.**
- **%age increase in immunization coverage.**
- **Hepatitis 'B'coverage provided to population.**

Note: This information should be with reference to previous condition and improvements.

3.7 Improving Referral System:

Every District Government has received sufficient support from different agencies to upgrade / strengthen the existing referral system so as from SDSSP first year support. At this point in time DGs are required to compile facility wise inventory of, vehicles (Ambulances) with complete detailed information depicting its model and make to whether it is on road or off and since when. This will help planners to identify needs and allocation of funds.

Besides this, communication mechanism between various levels should be established to make referral system more effective. Therefore district governments while considering their sectoral priorities can evolve strategic referral mechanism so that efficient service delivery could be ensured.

3.8 Avoidance of Duplication:

At district level, different stake holders are working besides government. In health sector many NGOs, UN agencies, other donors are already providing various services mainly through existing health facilities. While making annual sector plan and subsequent schemes it is essential to clearly identify areas where investment is directed to avoid resources and effort wastage.

It is therefore imperative to evolve a mechanism that clearly coordinate with all actors in the field to pool resources and prioritize the activities/ schemes with the concept of making each health unit a viable and qualitative entity.

4.0 Checklists

Following checklists have been provided to ensure that proper procedures are adopted in planning process and relevant documents attached and necessary tables are duly filled.

The first draft of ASP should be prepared and then submit to PSU-SDSSP after the detailed consultation and under the guidance of Council's Health Sector Committee but before submitting it to Budget and Development Committee (BDC) (Checklist I).

The second draft of ASP, after inclusion of all observations of PSU, would be submitted to Provincial Health Department for their views and comments. The amendments /additions in first draft of ASP should be done in consultation with Health Sector Committee of the Council (Checklist II).

Health Sector Committee, incorporating all the observations of Provincial Health Department, would submit the ASP to (Budget and Development Committee (BDC)). The BDC would process the plan and will table the plan for Council approval. A copy of the approved ASP would be furnished to PSU-SDSSP for the purpose of release of funds (Checklist III).

4.1 Checklist I: (for District Government)

1. Section One: Situation Analysis- Brief description of district's health sector has been assessed and included in ASP (table 1.1 to 1.4 filled). **Yes/ No.**
2. Sections Two: On-going activities- ASP details all the ongoing development activities, current years ADP, previous years ADP, Federal / Provincial grants/ donor's schemes have been listed in ASP (table 2.1 to 2.5 filled). **Yes/ No.**
3. Section Three: SDSSP proposed schemes- all the proposed schemes are as per the MoUs scope and processes (table 3.1-3.2). **Yes/ No.**
4. All the schemes of SDSSP have been filled in the enclosed "Investment Proposal Performa". **Yes/ No.**
5. All the minutes of the meeting that were held in process of formulating the plan have been attached. **Yes/ No**.
6. Abstract of the Schemes filled (Performa: ABS-H-II). **Yes /No.**
7. Summary Report about SDSSP schemes FY 04-05 filled (Performa: SCR (H)-I) **Yes/No.**

Signed by

____

Executive District Officer (Health)

4.2 Checklist II: (for Health Department)

Date ASP received in the Department: ______________
Date ASP examined: ______________

1. Annual Sector Plan does not violate any provincial policy or guideline. **Yes/ No.**

2. ASP reflects the provincial priority areas. **Yes/ No.**

3. ASP does not contain any scheme that pertains to un-devolved area of health sector. **Yes/ No.**
4. The objections / observations of the department (if any) have been communicated to District Government. **Yes/ No.**

In case of "No" please specify reasons (use additional sheets if required).

1. ____

   ____

2. ____

   ____

3. ____

   ____

4. ____

   ____

1. Signature: ___________	2. Signature: ___________
Name: _______________	Name: _______________
Designation: _____________	Designation: _____________

4.3 Checklist III: (for District Government)

1. All the steps required in Checklist I have been fulfilled. **Yes/ No.**
2. Approved ASP has accommodated all the observations of the Provincial Health Department (if any). **Yes/ No.**
3. The district resolution, approving the ASP, attached. **Yes/ No.**
4. The softcopy of ASP (computer/digital format in CD) attached. **Yes/ No.**

In case of "No" please specify reasons (use additional sheets if required).

1. ____

   ____

2. ____

   ____

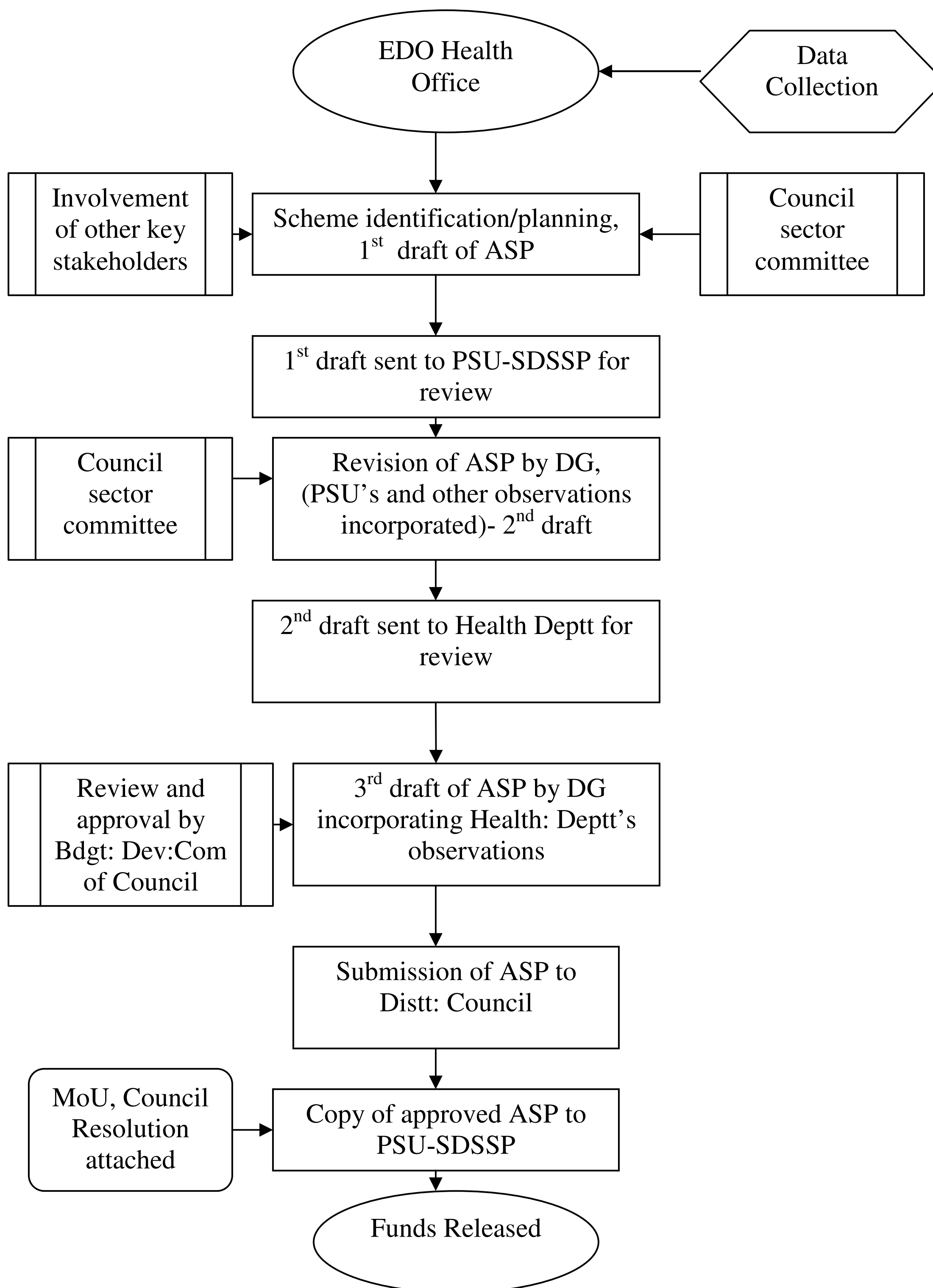
3. ____

   ____

Signed by

____
Executive District Officer (Health)

4.4 Flow Chart



5.0 Investment Proposal

I. Name of Scheme ________________________

II. Commencement Date of scheme: _________________

III. Completion Date of scheme: _________________

IV. Provide a brief analysis of the Current situation (issues/ problems/on-going efforts)
____
____
____

V. Main description and objective
____.

VI. Please indicate how the gender/environmental /poverty aspects of the project have been taken into account.

____.

VII. State the Need Assessment process and involvement of key stakeholders (provincial department, concerned district departments, Health management committees etc.)

VIII. Scheme beneficiaries:

Age Group	Male	Female	Total

IX Scheme Management / Monitoring

a. How will the monitoring activity will be carried out of the schemes?
____.

b. Explain the system of keeping record and reporting of information.
____.

i. Total Cost of the project

a.	Total Cost of the scheme	
b.	Development	
c.	Yearly Recurrent after the completion of the scheme	
i.	Salary	
ii.	Non Salary	
d.	Sources of funding of recurring cost	

ii. Staffing Details after Completion of Scheme

Sr.#	BPS	No. of Posts	Designation	Sanctioned			
				Male	Female	Male or Female	Total

iii. Proposed Progress Reporting Schedule

Sr. #	Name/details of Scheme	Date/ Frequency of Submission

X. Scheme Preparation/Approval.

Prepared by ___________________ Date _______________
Checked by ___________________ Date _______________
Approved by __________________ Date _______________
Administrative Approval by ______________________ Date _________________
Technical Sanction by ___________________ Date _________________